
# County of Los Angeles
# Department of Mental Health

## Contract Providers Transition Project (CPTP)

## EDI Deny Reason Cheat Sheet

**Version 1.7**

**February 2011**

# DOCUMENT REVISION HISTORY

| Version | Release Date | Revised by | Comments/Indicate Sections Revised |
|---|---|---|---|
| Revised | 04/14/2009 | Karen Bollow | New Link for EDI Errors |
| Revised V 1.2 | 08/13/2009 | Marta Ghazarian | Minor Updates |
| Revised V 1.3 | 01/12/2010 | Karen Bollow | New Link for EDI Day Treatment Errors |
| Revised V 1.4 | 03/26/2010 | Karen Bollow | Updated Error Codes |
| Revised V 1.5 | 08/10/2010 | Karen Bollow | Updated Late Code 3 Errors |
| Revised V 1.6 | 09/14/2010 | Karen Bollow | Updated Late Code 11 Errors |
| Revised V 1.7 | 02/17/2011 | Karen Bollow | Updated for Replacement of Denials |

# EDI DENY REASON CHEAT SHEET

## INBOUND 837 PROFESSIONAL IS BUSINESS RULES

| DenyRuleFailure | Corrective action to be taken |
|---|---|
| (Inb837P.Post.4) Check for Duplicate | The same Claim Id came in 2xs. This is common for providers who submit through EDI, but should not occur for user who submit claims from Admin. This had occurred for those that submit through Admin on certain occasions where claims were suspended and were then resubmitted. Call the help desk at 213-351-1335. |
| (Inb837P.Post.5) Validate Void Claim | If the claim is a void or resubmitted claim (2300_CLM05 = “8” 0r “7”) ensure its referenced inbound claim exists. |
| (Inb837P.Post.5a) Validate Void/Replace Prior to Claim ID or Deny Source | This rule ensures the proper previous claim is sent. |
| (Inb837P.Post.5c) Prev Resub Status For Resub | Attempted to Re-Submit a transaction that was not in DENIED status. |
| (Inb837.Post.5d) Cannot Void a Claim Previously Voided | |
| (Inb837.Post.5e) Validate Void/Resub Parent Claim | |
| (Inb837P.Post.7) Validate Billing, Pay To Provider, Service Location and Rendering Provider | The billing provider (2010AA_REF) must exist in the IS and be active on the service date of the claim. Use IS 290 report for verification. The Billing Provider, Service Location and Rendering Provider in the claim must be associated to each other and must be active on the service date. |
| (Inb837P.Post.10) Validate Subscriber Enrollment | Verify the subscriber (client) is enrolled with DMH and is a person. Note that the value in the claim is the client’s DMH ID. Also may be related to client’s death date. |
| (Inb837P.Post.11) Validate Payer | Verify the payer referenced on the inbound 837 claim is DMH. |
| (Inb837P.Post.12c) Validate Procedure Code | |
| (Inb837P.Post.12d) Validate Rendering Provider | This is the rendering provider. The provider’s internal id must be in 2310BREF_RenderingProviderSecondaryIdentification where 2310B_REF01 = “N5” Use the rendering provider (2310B_REF02) to retrieve its staff code from the repository. |
| (Inb837.Post.12e)Validate Service Time | |
| (Inb837P.Post.17) Validate Medicare and Insurance Coverage | For contract providers, Medicare and Insurance claims are submitted before submitting through the IS. Make sure there is an amount paid even if it is $0.00. For directly operated providers Medicare amount paid should equal $0.00. For Other Insurance, both D.O.P. and C.P. may enter an amount received. |
| (Inb837P.Post.19) Validate Late Claims for Delay R | If a claim is filed more than 6 months after the service date, there must be a delay reason code. |
| (Inb837P.Post.23) Validate Birth Date against Date of Death | Ensure the subscriber’s birth date is not after the date of death. |
| (Inb837P.Post.25) Validate Single Service | |
| (Inb837P.Post.26) Validate DMH Plan | If DMH is referenced as another payer (2330B), a valid plan (2330A_REF) must be present. |
| (Inb837P.Post.27) Validate Procedure Code | |
| (Inb837P.Post.28) Validate Service Date Against | Ensure the service date is not more that a year before the current date. |

# INBOUND 837 PROFESSIONAL IS BUSINESS RULES

| DenyRuleFailure | Corrective action to be taken |
|---|---|
| Current Date | |
| (Inb837P.Post.29) Validate FFS 2 Rendering Provider Taxonomy | |
| (Inb837P.Post.31) Validate FFS Medical Payer | If the claim is from FFS 2 provider, ensure Medi-Cal is sent as a payer in the 2320 loop. |
| (Inb837P.Post.33) Validate FFS Rate Conversion information is available | If the claim is from FFS 2 provider, ensure the procedure code is valid. |
| (Inb837P.Post.35) Validate FFS delay reason code | If the claim is from FFS 2 provider, and if the current date is more than 6 months from the service date<br><br>07/07/2006 – As per DMH modify as follows:<br>Execute Rule always – regardless of whether claim is late or not,<br>and Do not accept 2, 5, 6, 7, 9, 10. Therefore only 1, 3, 8 and 11 are valid<br><br>7/13/2010 – As per DMH only allow late code 3 if Medi-Cal is a billable payer and Medicare is a payer in the claim. This will only be allowed for a period of time and is based on a flag setting of 'ON' (i.e. allowed as per above conditions), or 'OFF' (i.e. not allowed at all).<br>8/10/2010 – As per DMH only allow late code 11 if the claim meets the SD II Good Cause criteria or if a TAR number is present |
| (Inb837P.Post.37) Validate Diagnosis | Ensure the ICD-9 diagnosis code converts to a DSMIV code. There may be a problem with the ICD-9 – DSMIV crosswalk. Call the help desk at 213-351-1335. |
| (Inb837P.Post.39) Validate Medi-Cal & Medicare ID | If Medical is specified as a payer ensure the clients Medi-Cal ID is in the CIN format - 8 digits and a letter (e.g. 12345678A). For claims from LP Directed Operated, if Medicare is specified as a payer ensure the clients Medicare ID is in the format a minimum of 9 and a max of 12 (e.g. A12345678XYZA). |
| (Inb837P.Post.43) Validate LP Delay Reason Code | For claims from LP providers, the delay reason code cannot be 5, 6 or 9<br><br>1/4/2007 – As per DMH do not allow late code 2 or 10. Therefore only 1, 3, 7, 8 and 11 are valid.<br><br>7/13/2010 – As per DMH only allow late code 3 if Medi-Cal is a billable payer and the client has a Medicare ID. This will only be allowed for a period of time and is based on a flag setting of 'ON' (i.e. allowed as per above conditions), or 'OFF' (i.e. not allowed at all).<br>8/10/2010 - As per DMH only allow late code 11 if the claim meets the SD II Good Cause criteria |
| (Inb837P.Post.45) Validate Service Time | Other and Face-to-Face time are zeroes. |
| (Inb837P.Post.48) Validate Client has not been cross referenced | |
| (Inb837P.Post.50) Validate mode of service location consist with proc code service type | Validate mode of service location consist with proc code service type– Added 6/17/2004 Verify the hrp_provider.mode for the service loc (RU where the service took place). If mode = 10, then we need to make sure that for the proc code listed, hrp_DMHProcedure.Servicetype=O and hrp_DMHProcedure.DayTrmt = Y. |
| (Inb837P.Post.51) Validate Date string is consistent with date qualifier | |
| (Inb837P.Post.52) Validate Service Location Medical ID | For Local Plan Providers (DO & Contract), if Medi-Cal is a payer and can be billed, ensure the service location Medi-Cal ID is active. Medi-Cal can be billed when:<br>• All the plans in the claim allow Medi-Cal to be billed, |

# INBOUND 837 PROFESSIONAL IS BUSINESS RULES

| DenyRuleFailure | Corrective action to be taken |
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| | • And the procedure code can be converted to a Medi-Cal procedure code. |
| (Inb837P.Post.55) Validate FFS 2 Prior Auth Number | Rule added to address the gap between what is allowed in the FFS system for Prior Authorization numbers from what is allowed in the HIPAA 837 guide. In the FFS system, this number is restricted to 11 digits. If a claim is received where the prior authorization > 11 digits, deny the claim. |
| | |
| (Inb837P.Post.60) Validate EPIS exists for LP SFT claims | For LP claims submitted via SFT, the IS needs to validate that there is a valid episode existing in Clinical for the service being claimed. The episode admit date must be <= to the claim service date The episode discharge date, if present, must be > than the service date payer is 3rd party |
| (Inb837P.Post.61) Validate Client Address | Ensure client address ADDRESS1, CITY, STATE, POSTALCODE and COUNTRY are not empty and no '&' exists. |
| (Inb837P.Post.64) Validate Medicare & Insurance Paid Amount | Ensure any Medicare and Insurance paid amounts are not greater than the claim amount. Changed to ensure Medicare and Insurance paid amounts are not greater than lesser of claim or contract amount for LP Contract Claims. Also, for FFS ensure Medicare and Insurance payment amounts are not greater than claim amount (IS does not have FFS contract rates). |
| (Inb837.Post.67) Validate Provider Taxonomy | Ensure taxonomy in the claim is valid |
| (Inb837P.Post.68) Validate Void Service Date | MHMIS (and DMH Business rules) require that the discharge date = last date of service, therefore if a discharge date exists, the last service date cannot be voided. The user must first remove the discharge date and then void. To remove discharge date, the user must make a request to EUS. |
| (Inb837P.Post.72) Validate Release of Information Code | Ensure CLM9 = 'Y' |
| (Inb837P.Post.73) Validate Patient Signature Code | Ensure CLM10 = 'B' |
| (Inb837P.Post.76) Validate NPI Exists in Billing Provider Node for EDI Claims | If claim is from LP Contract and Medi-Cal is a billable payer , ensure the NPI is sent in the billing provider node. If the NPI exists, ensure that it is 10 digits and passes the NPI algorithm check.<br>For all FFS EDI claims , ensure the NPI is sent in the billing provider node. If the NPI exists, ensure that it is 10 digits and passes the NPI algorithm check.<br>- NOTE: For all FFS EDI Claims, this rule assumes Medi-Cal is a payer - – which is validated for FFS claims in a previous rule<br>7/1/008 (CR76-4): Ensure the NPI cannot start with zero |
| (Inb837P.Post.78) Validate NPI Exists in Billing Provider Node for EDI Claims | For LP Contract EDI Claims if Medi-Cal is a billable payer and the service location is not a satellite or public school, ensure the NPI in the EDI Claim (2010AA_NM109 where NM108 = 'XX") matches the billing provider NPI in the IS.<br>- NOTE: This check assumes Rule 76 has passed<br>For FFS EDI claims ensure the NPI in the 2010AA segment matches the billing provider NPI in IS.<br>- NOTE: For all FFS EDI Claims, this rule assumes Medi-Cal is a payer - – which is validated for FFS claims in a previous rule |
| (Inb837P.Post.79) Validate Rendering Provider NPI is sent for EDI Claim | For LP Contract EDI Claims, if Medi-Cal is a billable payer ensure the rendering provider NPI is sent in the rendering provider node. If the NPI exists, also ensure that it is 10 digits and passes the NPI algorithm check<br>For FFS EDI claims, ensure the rendering provider NPI is sent in the rendering provider node. If the NPI exists, also ensure that it is 10 digits and passes the NPI algorithm check.<br>- NOTE: For all FFS EDI Claims, this rule assumes Medi-Cal is a payer - – which is validated for FFS claims in a previous rule<br>7/1/008 (CR76-4): Ensure the NPI cannot start with zero |

# INBOUND 837 PROFESSIONAL IS BUSINESS RULES

| DenyRuleFailure | Corrective action to be taken |
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| (Inb837P.Post.80) Validate Rendering Provider NPI matches IS for EDI Claim | For LP Contract EDI Claims, if Medi-Cal is a billable payer, ensure that the rendering provider NPI in the 2310B segment matches the rendering provider NPI in IS.<br>- NOTE: This check assumes Rule 79 has passed<br>For FFS EDI Claims, ensure that the rendering provider NPI in the 2310B segment matches the rendering provider NPI in IS.<br>NOTE: This check assumes Rule 79 has passed. NOTE: For all FFS EDI Claims, this rule assumes Medi-Cal is a payer - – which is validated for FFS claims in a previous rule |
| (Inb837P.Post.82) Reject Duplicate Crisis Stabilization | Do not allow duplicate Crisis Stabilization claims |
| (Inb837P.Post.85) | Validate Claim Plan Sequence Number |
| (Inb837P.Post.86) | Validate Medi-Cal Billable Late Claims |
| (Inb837P.Post.88) Check for LP Contract Duplicate Outpatient Claim. | For LP Contract, if the procedure code is outpatient ensure a non-voided claim that has not been denied by business rules (RULES, DTA, CICS) does not already exist with the same Client, Service Location, Rendering Provider, Procedure Code, Service date and Service Time. If a claim already exists and the duplicate override is not sent the claim will be denied |
| (Inb837P.Post.89) Validate procedure code for Med-Cal Claims | For LP Contract if Medi-Cal is selected as a payer and procedure code is not Medi-Cal billable the claim will be denied . |
| (Inb837P.Post.90) Validate plan for Medi-Cal Claims | For LP Contract if Medi-Cal is selected as a payer and plan is not Medi-Cal billable the claim will be denied . |
| (Inb837P.Post.91) Validate Net Remaining Amount for Medi-Cal Claims | For LP Contract if Medi-Cal is selected as a payer and net remaining to be paid is zero or less, the claim will be denied.<br>Net Remaining is calculated as lesser of Claim or Contract amount minus sum of Other Insurance, Medicare, and SOC Obligation.<br>2/8/2010: Ensure Net Remaining for FFS cannot be zero or less. For FFS net remaining is calculated as Claim Amount minus sum of Other Insurance, Medicare, and SOC Obligation |
| (Inb837P.Post.92) Validate Medicare and Other Ins Adjudication Date. | For each prior payer (Medicare or Other Insurance), if the adjudication date of the payer is not sent in the claim, or the date is not after the date of service the claim will be denied. |
| (Inb837P.Post.93) Validate Client Gender for Pregnancy Claims. | If Pregnancy is selected and client is not female claim will be denied. |
| (Inb837P.Post.94) Validate SD II Void Claims | If a SD II claim is voided claim will be denied. |
| (Inb837P.Post.96) Validate Evidence Based Practice Code | For LP providers, ensure claim has at least one EBP code and no more than 3.<br>EBP code is in 2300_NTE_ClaimNote segment with the following field values<br>• 2300_NTE01_NoteReferenceCode = 'DCP'<br>• 2300_NTE02_ClaimNoteText = EBP code<br>- There can be up to 3 EBP codes and each code will be separated by a hyphen ('-')<br>NOTE: For 837p the 2300_NTE_ClaimNote segment can occur only once. Therefore this segment must always exist and 2300_NTE01_NoteReferenceCode must always = 'DCP' |

| INBOUND 837 PROFESSIONAL IS BUSINESS RULES | |
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| **DenyRuleFailure** | **Corrective action to be taken** |
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| (Inb837P.Post.97) Allow Replacement Claims for SD II Only | The submission of replacements are only allowed for SD II Medi-Cal LP provider claims previously denied by Medi-Cal. SD I claims cannot be replaced. Providers will need to submit an inbound original claim for any denied SD I claim. |
| (Inb837P.Post.98) Allow Only One Replacement Claim to Medi-Cal | Replacement claims that include Medi-Cal as a billable payer will not be accepted if a Medi-Cal replacement claim was previously created for the service. This will result in EDI denial of the replacement claim or DDE hard edit upon submission of the claim. Hard edit for DDE and EDI claims will not allow the replacement if it is billable to Medi-Cal and a previous replacement claim has already been sent to Medi-Cal. |
| (Inb837P.Post.99) Validate Replacement Claim Client CIN | Hard edit for DDE and EDI claim will not allow the replacement if it is billable to Medi-Cal and the client's CIN does not match the CIN sent on the previous claim to Medi-Cal. |
| (Inb837P.Post.5.2.E2) Ensure LP Service Location has Rate Table | If the claim is from Local Plan provider, ensure the service location has rate table. |
| (Inb837P.Post.5.2.E3) Ensure LP Service Location has Rate for Claim Plans and Procedure Code | If the CPT code in the claim is not billable under the Plan (i.e. Crisis Intervention is not allowed under AB3632) the claim will be denied, even if there is another Plan in the claim with the same CPT code that is billable to Medi-Cal (Crisis Intervention is billable under EPSDT). Call help desk for report at 213-351-1335. |

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| **INBOUND 837 INSTITUTIONAL IS BUSINESS RULES** | |
| **DenyRuleFailure** | **Corrective action to be taken** |
| (Inb837I.Post.4) Validate Void Claim. | If the claim is a void or resubmitted claim (2300_CLM05 = “8” 0r “7”) ensure its associated original inbound claim exists. |
| (inb837I.Post.4a) Validate Void/Replace Prior Claim ID or Deny Source | This rule ensures the proper previous claim is sent. |
| (Inb837I.Post.19) Validate Medi-Cal & Medicare ID | If DMH is referenced as another payer (2330B), a valid plan (2330A_REF) must be present.<br>1/8/2010: Turn on and also ensure there is a plan in the EDI claim. As per DMH, plan of CGF for LP and plan of MCF for FFS will no longer be defaulted if there is not a plan in the inbound claim |
| (Inb83 I.Post.25) Validate Medi-Cal and Medicare ID | If Medical is specified as a payer ensure the clients Medi-Cal ID is in the CIN format - 8 digits and a letter (e.g. 12345678A). For claims from LP Directed Operated, if Medicare is specified as a payer ensure the clients Medicare ID is in the format a minimum of 9 and a max of 12 (e.g. A12345678XYZA). MHMIS EPI2 screen requires this format.<br>With SD II, Healthy Families indicator is no longer a part of the CIN. Therefore the CIN must always be length of 9. |
| (Inb837 I.Post.27) Validate LP Delay Reason Code | For claims from LP providers, the delay reason code cannot be 5, 6, or 9 .<br><br>1/4/2007 – As per DMH do not allow late code 2 or 10. Therefore only 1, 3, 7, 8 and 11 are valid.<br><br>7/13/2010 – As per DMH only allow late code 3 if Medi-Cal is a billable payer and the client has a Medicare ID. This will only be allowed for a period of time and is based on a flag setting of ‘ON’ (i.e. allowed as per above conditions), or ‘OFF’ (i.e. not allowed at all).<br>8/10/2010 - As per DMH only allow late code 11 if the claim meets the SD II Good Cause criteria |
| (Inb837I.Post.41) Validate Medicare and Insurance Paid Amount | Ensure any Medicare and Insurance paid amounts are not greater than the claim amount.<br>NOTE: Even though MHMIS no longer is an issue, DMH business rules require previous payment amounts cannot > claims/contract amounts |
| (Inb837I.Post.57) Validate Procedure Code for Medi-Cal Claims | For LP Contract if Medi-Cal is selected as a payer and procedure code is not Medi-Cal billable the claim will be denied . |
| (Inb837I.Post.58) Validate Plan for Medi-Cal Claims | For LP Contract if Medi-Cal is selected as a payer and plan is not Medi-Cal billable the claim will be denied . |
| (Inb837I.Post.59) Validate Net Remaining Amount for Medi-Cal Claims | For LP Contract if Medi-Cal is selected as a payer and net remaining to be paid is zero or less, the claim will be denied.<br>Net Remaining is calculated as lesser of Claim or Contract amount minus sum of Other Insurance, Medicare, and SOC Obligation. |
| (Inb837I.Post.60) Validate Medicare and Other Ins Adjudication Date | For each prior payer (Medicare or Other Insurance), if the adjudication date of the payer is not sent in the claim, or the date is not after the date of service the claim will be denied.<br>NOTE: This is not checked for claims from FFS DDE (from Admin). |
| (Inb837I.Post.61) Validate Client Gender for Pregnancy Claims | If Pregnancy is selected and client is not female claim will be denied.<br>NOTE:<br>• For LP & FFS EDI claims Pregnancy is found in 2000B PAT09 Pregnancy Indicatory = ‘Y’ |

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| **INBOUND 837 INSTITUTIONAL IS BUSINESS RULES** | |
| **DenyRuleFailure** | **Corrective action to be taken** |
| | • For FFS DDE claims, pregnancy is found in the 2320 loop where 2330B is for Other Insurance and 2330A_NM109 = 'PG'<br><br>3/8/2010 Ensure all references of gender in claim match IS database |
| (Inb837I.Post.62) Validate SD II Void Claims | If a SD II claim is voided claim will be denied.<br>NOTE:<br>• Upon implementation of CR 102 (Claim Submission Cutoff) on Jan 7 SD I vs. SD II claims are set as follows<br>- All existing submitted claims will be marked as SD I<br>- All existing unsubmitted services (i.e. in New or Administrative status) will be marked as SD II<br>- Any newly created service/claim will be SD II<br>• Upon implementation of SD II changes all new services and claims will be marked as SD II |
| (Inb837I.Post.64) Validate Evidence Based Practice Code | For LP providers, ensure claim has at least one EBP code and no more than 3. EBP code is in 2300_NTE_ClaimNote segment with the following field values<br>• 2300_NTE01_NoteReferenceCode = 'DCP'<br>• 2300_NTE02_ClaimNoteText = EBP code<br>- There can be up to 3 EBP codes and each code will be separated by a hyphen ('-')<br>NOTE: 873i transaction allows multiple 2300_NTE_ClaimNote segments. As such only the first segment where 2300_NTE01_NoteReferenceCode = 'DCP' will be used |
| (Inb837I.Post.65) Allow Replacement Claims for SD II Only | The submission of replacements are only allowed for SD II Medi-Cal LP provider claims previously denied by Medi-Cal. SD I claims cannot be replaced. Providers will need to submit an inbound original claim for any denied SD I claim. |
| (Inb837I.Post.66) Allow Only One Replacement Claim to Medi-Cal | Replacement claims that include Medi-Cal as a billable payer will not be accepted if a Medi-Cal replacement claim was previously created for the service. This will result in EDI denial of the replacement claim or DDE hard edit upon submission of the claim. Hard edit for DDE and EDI claims will not allow the replacement if it is billable to Medi-Cal and a previous replacement claim has already been sent to Medi-Cal. |
| (Inb837I.Post.67) Validate Replacement Claim Client CIN | Hard edit for DDE and EDI claim will not allow the replacement if it is billable to Medi-Cal and the client's CIN does not match the CIN sent on the previous claim to Medi-Cal. |
| (Inb837I.Post.68) Validate Diagnosis Code | Ensure the diagnosis codes are valid.<br>For all claims, ensure the ICD9-CM diagnosis exists based on DMH crosswalk for converting ICD9 to DSM IV (Direction 1 is used). Check all the diagnosis codes in the claim. Do not check if the code is in the ICD9 code list.<br>837I Main Diagnosis node is TS837Q3_2300_HI_PrincipalAdmittingECodeAndPatientReasonForVisitDiagnosisInformation<br><br>Fields |

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| **INBOUND 837 INSTITUTIONAL IS BUSINESS RULES** | |
| **DenyRuleFailure** | **Corrective action to be taken** |
| | TS837Q3_2300_HI01_C022U1102<br>TS837Q3_2300_HI01_C02202U1104_IndustryCode<br>TS837Q3_2300_HI02_C022U1110<br>TS837Q3_2300_HI02_C02202U1112_IndustryCode<br>TS837Q3_2300_HI03_C022U1118<br>TS837Q3_2300_HI03_C02202U1120_IndustryCode |

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| WSC04 | DTI/DR Duplicate Claim |
| WSC05 | Resub claims are not allowed for DTI/DR claims. Void and submit an original. (Terminated 02/17/11) |
| WSC07 | The original claim being voided is not found. Please call the Help Desk at (213) 351-1335 |
| WSDT01 | No DTI/DR Authorization Found |
| WSDT02 | No DTI/DR days left for original claim. No DTI/DR days used for void claim. |
| WSDT04 | DT/DR Replacement Error. Please call the Help Desk at (213) 351-1335 |
| WSDT05 | DTI/DR Replacement Validation Error. Void and submit an original claim |
| WSMHS01 | No MHS Authorization Found |
| WSMHS02 | Original claim not enough MHS hours left. Void claim no hours used for the week. (Display # of Hours Left) |
| WSMHS04 | MHS re-sub hours must be less than or equal to remaining hours. |
| WSMHS05 | MHS re-sub validation error. Void and submit an original claim |
| WSMHS09 | MHS re-sub error. Please call the Help Desk at (213) 351-1335 |

Other UOFS error codes that have been changed to IS rule:

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| LAMH0089 | LAMH0089-INVALID DATE |
| LAMH4090 | LAMH4090-STAFF CODE/REPT UNIT UNMATCHED |
| LAMH6019 | LAMH6019 - DUPLICATE DAY TREATMENT |
| LAMHDT01 | LAMHDT01-NO TBS AUTHORIZATION FOUND |
| LAMHDT03 | LAMHDT03-NO DTI AUTHORIZATION FOUND |